



Illinois Public Health Institute works through partnerships to promote prevention and improve public health systems that maximize health and quality of life for the people of Illinois.

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January 22, 2013

Julie Hamos
Director
Illinois Department of Healthcare and Family Services
401 S. Clinton Street
Chicago, IL 60607

Dear Director Hamos:

Thank you for the opportunity to comment on Illinois' Medicaid waiver request. The Illinois Path to Transformation and the related 1115 Medicaid waiver are groundbreaking and visionary. We are extremely pleased to be able to partner with the Governor's office, the Department of Health Care and Family Services, HMA and the members of the Alliance for Health to craft this transformative initiative.

Chronic diseases are one of the most significant drivers of health care costs, yet they are often completely or mostly preventable by mitigating risk factors like obesity, sedentary lifestyles, unhealthy eating and environmental influences

We note that this waiver request document describes several proposals that strengthen the population health aspects beyond patients to communities and will help the delivery system move toward preventing disease and creating a healthier, and thus less costly population overall.

Pathway 2 – Population Health

1) We applaud the decision to “create a premium add-on payment for health plans that agree to use the funds to develop population health interventions in conjunction with newly created Regional Public Health Hubs.” (p. 21). We suggest that this innovation be expanded to include not just plans, but also an **add-on to incentivize similar activities by providers, such as hospitals and FQHCs**. The request should specify the types of interventions sought by population health add-ons, such as:

- Actively partnering with community groups to identify and collaborate to ameliorate overall barriers to health in the community that affect both patients and everyone else, for instance, working to increase access to healthy foods or improving sidewalks and crosswalks to promote walking and safety. The CCHHS initiative to address food insecurity is a good example, though it could go further and address food access in communities in partnership with CCDPH.
- It is particularly important to engage non-profit hospitals in this work because of their new Community Health Needs Assessments requirements under ACA. **Such hospitals should be incentivized to align their activities and collaborate**, such as through the Regional Hubs.

Pathway 1: Delivery System Reform

2) The concept of addressing food insecurity as described in the CCHHS initiative suggests that there is a patient screening mechanism to determine if the patient is food insecure. This concept should be expanded via the Path to Transformation **to create a common minimum set of “social determinants” of health for which all patients served would be screened**. Such screening data can be aggregated and assist plans, providers, communities and the Regional Hubs to identify community prevention needs.

3) We believe that plans and providers are likely not well-versed in community-based prevention and disease management strategies and may not have the relationships in place to partner to provide these services. **We would like to see specific proposals for paying non-traditional providers for community-based prevention**. The recent CMS decision that Medicaid can pay for unlicensed providers should facilitate this. Such payments should include both fee-for-service health care and requirements that Coordinated Care and Managed Care initiatives provide coverage for community-based services:

- Cover and pay for programs like the Diabetes Prevention Program (DPP), an evidence-based YMCA program.
- Cover and pay for programs like the Diabetes Self-Management and Chronic Disease Self-Management programs, often offered through health departments.

- Likewise, health departments provide tobacco cessation, nutrition counselling, etc. and should be reimbursed for those services by Medicaid and by CCEs, ACEs, HMOs and other providers and payers associated with the transformation of the delivery system.
- As was included in the approved 1115 waiver in Texas, we encourage the inclusion of a 5% set-aside fund for local health departments to partner with community-based organizations to invest in prevention and wellness strategies.

4) The waiver and the state-plan amendment(s) should also identify ways to more effectively promote prevention within the clinical setting. The following services and changes should be made to the state plan or identified in the waiver, whichever is appropriate:

- Require managed/coordinated care organizations to provide all of the US Preventive Services Task Force A & B recommended preventive services and reimburse for these services through for patients receiving care through the fee-for-service program. This change in the state plan will generate a 1% increase in the FMAP for these services (as described in the February 1, 2013 letter from CMS (SMD 13-002).
- For obesity prevention, in addition to community-based services, we strongly urge the department to use this opportunity to expand on its recent provider notice regarding childhood obesity treatment (a USPSTF recommendation) to:
 - Increase the number of allowable reimbursable visits for pediatric weight management to a number more consistent with the evidence-base. The current allowable three visits in six months is too few to produce the desired outcomes and is therefore likely to fail in achieving its goal of reducing weight trajectories and achieving long-term improved health and cost savings.
 - Expand the services to children under two years of age.
 - Provide a mechanism for children who do not show a “favorable outcome” in the first few visits to be provided with these services again at a later date. It is unconscionable that a child who does not show progress in weight management in just three visits would be prevented from ever having weight management services from their doctor again.

- Provide payment for existing intensive weight-management programs serving children.
- **Incentivize in managed/coordinated care programs and reimburse via fee-for-service the services of dietitians, nutritionists, psychologists and social workers** who are often better equipped than doctors, nurses and physician assistants to work with patients to achieve the lifestyle changes necessary to reduce their risk for or manage their chronic diseases.

Pathway 3: Workforce

5) We were pleased to see the inclusion in the GME section of “25% of funds for written curricula in population medicine based on practice in primary/general outpatient care settings. The curriculum must contain competencies in the following areas of population medicine: preventive care, the use of information technology for managing clinic patients, appropriate management of patient transitions of care, inter-professional team-based care and patient-centered decision making. Programs must document that all residents received at least 20 hours a year in instruction in these areas.” **We suggest adding components addressing community-based primary prevention and social determinants of health.**

Pathway 4: Home and Community Based Infrastructure

6) In the section on Moving from a Disability-Based to Needs-Based System, beginning on page 30, **we encourage a stronger focus on addressing co-morbid conditions and chronic disease in the disabled/behavioral health population.** Rates of chronic disease in these populations are significantly higher than in the population overall, and must be specifically considered in providing services to them.

Approach to Evaluation (p. 46)

7) The Path to Transformation envisions shared risk models such as ACEs, CCEs and HMOs producing savings and ROI for the plan/provider if they prevent and manage disease. It is important to recognize that health departments and other community wellness organizations support and deliver community-based prevention programs and policies which contribute to better health for the entire population, including Medicaid clients. In the section on evaluation, the waiver request and the plan for transformation should include an initiative to document

and quantify the ways in which the ROI that results from community contributions can be shared with or reinvested in the health departments and CBOs that have contributed to it.

Approach to Budget Neutrality

8) Also, we are very interested to see on the specific programs that will be included in the State Designated Health Programs for which you are seeking federal matching funds (p. 50) and hope that they include prevention programs delivered by the IDPH and IDHS.

Other

9) Finally, we note that the waiver request does not mention the Illinois Framework for Healthcare and Human Services, which shares the goal of adopting a “client-centered, no-wrong-door” approach to service delivery. **As you craft the story of large-scale transformation in Illinois, it may be beneficial to note that the Framework provides a strategic platform for developing shared technical infrastructure and coordinated business processes between state agencies and their community-based service providers.** Interoperable systems will be a necessary component for exchanging client data and managing client services and it is likely important to convey to federal decision-makers that efforts in this regard are being coordinated across initiatives they are funding. We believe that the Framework will be important to achieving the goals of the Path for Transformation.

Again, we thank you for this opportunity to comment on the waiver request, and for the opportunity to participate in the Path to Transformation initiative. We look forward with great anticipation to the next steps.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elissa Bassler', with a stylized, cursive script.

Elissa J. Bassler
CEO